Surrey and Sussex Healthcare
NHS Trust

Serious Incident Report (January 2021)
Trust Board - public

Date: Thursday 28th January 2021
Agenda item: 2.4

Executive sponsor	Jane Dickson, Chief Nurse
Report author(s)	Katharine Horner, Patient Safety and Risk Lead
Report discussed previously: (name of sub-committee/group and date)	n/a

Action required:		
Approval ()	Discussion ( )	Assurance (✓)

Purpose of report:

This paper provides the Board of Directors with a report on the serious incidents declared in November and December 2020, with an update on the overall position with regard to the management of serious incidents within the Trust.

Summary of key issues

- The Trust declared four serious incidents in November and five in December 2020.
- In accordance with NHSE/I guidance the Trust has declared two serious incidents relating to Covid outbreaks which resulted in severe harm or death to patients. In addition a further serious incident has been declared following the death of a patient following the acquisition of Covid in hospital.
- As at 12th January 2021 the Trust is managing a total of eighteen serious incidents, of which eight have been submitted to the CCG for closure and ten are under investigation by the Trust.
- In addition three serious incidents are being investigated by the Healthcare Safety Investigation Bureau.
- Meeting the 60 day national standard remains a challenge for Divisions.
- The Duty of Candour report is attached for the information of the Board. The detail is monitored at the Serious Incident Review Group.

Recommendation:

The Board is asked to note the contents of this report.

Relationship to Trust strategic objectives and assurance framework:

SO1: Safe – Deliver safe, high quality care and *improving* services which pursue perfection and be in the top 25% of our peers SO2: Effective – As a teaching hospital, deliver effective and improving sustainable clinical services within the local health economy SO3: Caring – Work *with compassion* in partnership with patients, staff, families, carers *and community partners*

Corporate impact assessment	
Legal and regulatory impact	Compliance with CQC, MHRA and Audit Commission
Financial impact	Serious incidents often become claims
Patient experience/engagement	
Risk and performance management	Reporting, investigation and learning from serious incidents informs risk management
NHS Constitution/equality and diversity/communication	

Serious Incident Report (January 2021)
Trust Board - public

Date: Thursday 28th January 2021

1. Introduction – what are serious incidents?

1.1. A report on Serious Incidents (SI) is produced each month to provide assurance that incidents are being managed, investigated and acted upon appropriately and that action plans are developed from the Root Cause Analysis investigations.

1.2. This paper looks specifically at those incidents that are considered as SIs following the guidance from the NHS England's 'Serious Incident Framework" published March 2015.

1.3. A serious incident will be declared when one of the following criteria is judged to have been met:

1.3.1. Acts and/or omissions occurring as part of NHS-funded healthcare (including in the community) that result in the unexpected or avoidable death of one or more people.

1.3.2. Unexpected or avoidable injury to one or more people that has resulted in serious harm;

1.3.3. Unexpected or avoidable injury to one or more people that requires further treatment by a healthcare professional in order to prevent the death or serious harm to a service user.

1.3.4. Actual or alleged abuse; sexual abuse, physical or psychological ill-treatment, or acts of omission where healthcare did not take appropriate action/intervention to safeguard against such abuse occurring; or where abuse occurred during the provision of NHS-funded care.

1.3.5. A Never Event - all Never Events are defined as serious incidents although not all Never Events necessarily result in serious harm or death;

1.3.6. An incident (or series of incidents) that prevents, or threatens to prevent, an organisation's ability to continue to deliver an acceptable quality of healthcare services;

1.3.7. Major loss of confidence in the service, including prolonged adverse media coverage or public concern about the quality of healthcare or an organisation.

1.4. SI reports are reviewed and closed by Surrey Heartlands Clinical Commissioning Group.

2. The Process for the Management of Serious Incident

2.1. When an incident is identified that is serious or potentially serious in nature the priority is to ensure that the patient and/or the area is made safe and a senior manager is notified.

2.2. The incident is then documented on the Trust Incident reporting system and an immediate review undertaken. If it is felt that it meets the criteria of serious incident then it is escalated to the relevant Divisional leads.

2.3. A "Declaration Meeting" is then convened which is chaired by either the Chief Nurse or Medical Director. The meeting will review the incident with the facts available and secure all relevant evidence. If it is agreed that it meets the criteria of a serious incident then the meeting will set the terms of reference for the investigation and nominate an investigation lead.
2.4. The incident is reported on Strategic Executive Information System (STEIS) which informs the Trust's commissioners (CCG), NHS England and the CQC.
2.5. The investigation team have 60 working days in which to complete the investigation and write a root cause analysis (RCA). Each RCA is review within the Division before submission to a closure panel consisting of the Chief Nurse, Medical Director and Patient Safety & Risk Lead.
2.6. The RCA Is then submitted to Surrey and Heartlands Serious Incident Scrutiny Panel who, on behalf of the Trust Commissioners, review the final report and action plan to ensure it meets the requirement of a robust investigation. Additional information may be requested and feedback is given to the Trust as part of this process.
2.7. Only the CCG have the authority to close an investigation on STEIS.

3. Patient Safety Incidents in November and December 2020

3.1. There were a total of 934 incidents reported on Datixweb in November of which 755 (81%) were clinical/patient safety incidents, in December 821 incidents were reported of which 665 (81%) were patient safety incidents.

The patient safety incidents breakdown as follows:

	2020		
	October	November	October
None	511	508	440
Low harm	230	235	212
Moderate harm	20	8	9
Severe harm	1	2	2
Death	0	2	2
Total	**762**	**755**	**665**

As at 12th January, the percentage of harm incidents for November and December were 33% and 34%. A number of these incidents will be subject to ongoing review therefore it is reasonable that this percentage will change.

3.2. The incident categories are shown for those incidents reported as moderate harm, severe harm or death in November and December 2020.

	November & December 2020			
	Mod	Severe	Death	Total
Appointments	1	1		2
Care implementation	3	2		5
Clinical diagnosis			1	1
Communication & consent	1			1
Falls, slips and trips	2	1		3
Infection control	3		3	6
Maternity / Neonatal	2			2
Skin damage	3			3
Surgery operations	1			1
Treatment / Procedure	1			1
Total	**17**	**4**	**4**	**25**

4. Serious Incidents declared in November and December 2020

The Trust declared four serious incidents in November 2020.

- **2020/20811 (Sub-optimal care of a deteriorating patient, General Surgery)**
  The incident is the failure to recognise that the patient was suffering from malnutrition, weight loss and intestinal failure. As a result the patient did not receive TPN. It is the view of the Coroner that this omission was causal in the patient's death.

- **2020/21657 (Treatment delay, ED)**
  The patient, a 51 year old male, suffered a cardiac arrest in the waiting room of the emergency department. The incident will investigate the diagnostic process; the ECG and chest x-ray were not diagnostic and the Troponin results were delayed.

- **2020/21934 (Diagnostic incident)**
  A 75 year old male with cardiac resynchronisation therapy defibrillator in situ underwent an MRI. The clinician believed that the device was compatible, the radiographers receiving the request refused the MRI on the basis that the device was 'non-conditional'. The clinician made a repeat request which was accepted and the MRI was booked and went ahead.

- **2020/22369 (Hospital acquired Covid-19)**
  There have been three patients who have died since the outbreak of probably/definite hospital acquired COVID-19 on Newdigate and Leigh wards. 2 have been identified as having Covid-19 pneumonia as the main cause of death on their death certificate and 1 who has been referred to the coroner.

The Trust declared five serious incidents in December 2020.

- **2020/23029 (Fall, Discharge Unit)**
  A 92 year old lady suffered a fall whilst in the toilet on the discharge unit. The patient underwent diagnostic imaging and was then transferred to Crawley hospital to a rehabilitation bed. In the meantime the medical team reviewed the images and queried a fracture. As a result the patient was transferred back to East Surrey hospital for further treatment.

- **2020/23606 (Sub-optimal care of a deteriorating patient, AMU)**
  The patient was discharged from AMU and escorted by nursing staff to the bus stop. The patient collapsed at the bus stop and was taken back to the Emergency Department where he suffered a cardiac arrest and died.

- **2020/24813 (Hospital acquired Covid-19)**
  This incident is the confirmed SARS CoV-2 affecting a patient on day 16 of admission. COVID-19 was considered contributory to the patient's death, therefore this case fulfils definition of 'Hospital Onset Definite Healthcare Associated' (HO.dHA)

- **2020/24847 (Hospital acquired Covid-19)**
  Following the identification of a positive covid case in early December, the remaining five patients in the bay were managed as Covid contacts. Two further patients were subsequently confirmed positive, one of whom has died. This case fulfils definition of 'Hospital Onset Definite Healthcare Associated' (HO.dHA)

- **2020/25055 (Fall, Meadvale)**
  The incident is the witnessed fall of an 83 year old female patient, which resulted in a fractured neck of femur that required corrective surgery.

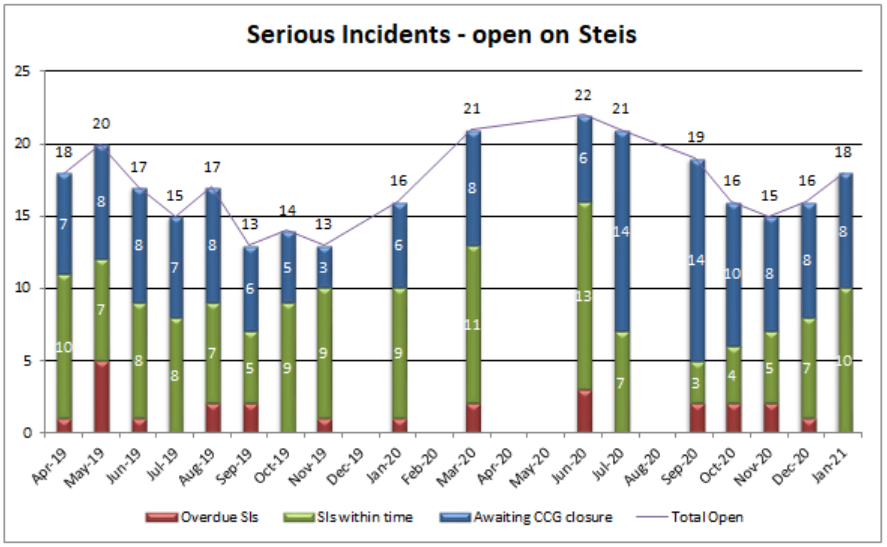
5. SI themes over the last 12 months

The serious incidents are shown by the month in which they occurred, not the month in which they were declared. The date of knowledge and therefore declaration may be different.

	Jan 2020	Feb 2020	Mar 2020	Apr 2020	May 2020	June 2020	July 2020	Aug 2020	Sept 2020	Oct 2020	Nov 2020	Dec 2020	Total
Care implementation				2	1				1		1		5
Clinical diagnosis	1	1		2			1					1	6
Diagnostic imaging											1		1
Falls		1	1	1		1	2		1	1	1	1	10
Infection control											2	1	3
Maternity / Neonatal				1	1			1					3
Pathology / Samples	1												1
Treatment / Procedure		1		1									2
Total	**2**	**3**	**1**	**7**	**2**	**1**	**3**	**1**	**2**	**1**	**5**	**3**	**31**

6. Serious Incident monitoring

The Trust Patient Safety and Risk Lead and Chief Nurse monitor Trust compliance and performance against the requirements of the NHS England Serious Incident Framework. The Serious Incident Review Group closely monitors the investigation and submission process. The Divisions are asked to include an update on RCA reports to the Patient Safety and Clinical Risk Sub-Committee. This is the latest reported Trust position at 12th January 2021 (excludes HSIB investigations):



	C&D	Corp	Med	Surg	WaCH	Total
Serious incidents under investigation:						
Breaching national 60 day deadline						0
Within timeframe			8	2		10
Total	**0**	**0**	**8**	**2**	**0**	**10**
Submitted to CCG - awaiting closure			3		5	8
Total Open SIs	**0**	**0**	**11**	**2**	**5**	**18**

There are three serious incidents under the management of the Healthcare Investigation. The triggers for a referral to HSIB are such that not all investigations are classed as a serious incident.

MATERNITY INCIDENTS UNDER THE MANAGEMENT OF HSIB

SI ID	Datix	Title / Incident Brief	STEIS date	Div	Current length of investigation	6 Month deadline	Status
2019/6569	101639	Maternity incident	20/03/19	WACH	459 days	18/09/19	Under investigation
2019/15761	104141	Maternity incident	17/07/19	WACH	378 days	15/01/20	Under investigation
2020/2321	110199	Maternity incident	04/02/20	WACH	238 days	30/04/20	Under investigation

The Trust is required to submit a final RCA within 60 working days of the date of declaration on STEIS. Submission performance for the Trust is shown below.

RCA report CCG submission performance						
	19/20 Q1	19/20 Q2	19/20 Q3	19/20 Q4	Total	
45 days	2	1	1		4	11%
45-60 days	2	6	6	4	18	47%
Over 60 days	9	3	2	2	16	42%
	13	10	9	6	38	
% compliance	31%	70%	78%	67%	58%	

Excludes HSIB

RCA report CCG submission performance						
	20/21 Q1	20/21 Q2	20/21 Q3	20/21 Q4	Total	
45 days	2	2			4	13%
45-60 days	5	5	3		13	41%
Over 60 days	6	5	4		15	47%
	13	12	7	0	32	
% compliance	54%	58%	43%		53%	

Excludes HSIB

The process of reviewing and approving each root cause analysis at a closure panel meeting with the Medical Director, Chief Nurse and Patient Safety Lead has now embedded and is part of the standard routine.

7. Serious Incident investigations closed by the CCG in November and December 2020

The Scrutiny Panel closed three serious incident investigations in November.

2020/13488 Fall, Radiology

The patient, a 79 year old gentleman, attended Crawley radiology department for a Computerised Tomography (CT) scan of his thorax with contrast in July 2020. Following the scan the patient reported feeling 'a bit funny'; he was given water and rested. He was then directed to the de-cannulation area, but on his way collapsed. He had further diagnostic imaging which found he had sustained a sacral fracture (break of the sacrum bone at the bottom of the spine), subarachnoid and intracerebral bleeding (bleeding in the brain). Following treatment he was discharged from East Surrey Hospital to Horsham patient rehabilitation centre and from there to a Nursing Home.

The investigation found that there was a failure to recognise and act on the clinical deterioration of the patient. It had been established that he was not feeling normal, he was seen holding the wall and was noted to be pale. Although the patient reassured each member of staff that he was fine (confirmation bias), he should have been guided to a point of safety and observed more closely.

The following recommendations were made and form the basis of the action plan:

1. To escort patients who have reported not feeling well post procedure or during imaging procedures.
2. Allocate resource to ensure patients post procedure are observed and monitored by clinical member of the team.
3. Review of the Nil By Mouth protocol for intravenous contrast CT examinations.
4. Offer patients suitable refreshments post IV contrast procedure if they have been required to be Nil by Mouth for examinations. Encourage patients who have been nil by mouth to bring a suitable snack to eat after the IC contrast procedure. The Trust could make basic refreshments available with appropriate dietary information with respect to allergies.
5. Explore role of CCTV in clinical setting to observe patient and identifying deteriorating patients, although it is acknowledged that this is not preventative.

2020/5609 Fall, IRU

This incident was the unwitnessed fall of a 66 year old male patient on the integrated reablement unit. The investigation found that the nurse in the bay went behind curtains to assist another patient, therefore was unable to maintain close observation of other patients in the bay. Additional staff should have been allocated to the team to support the need for a close observation bay. Finally, the patient should have been allocated a falls bed, this was omitted from the falls risk assessment.

The following lessons learnt were documents in the report:

1. To assess staffing levels each shift in relation to patient safety including cover for breaks to enable someone to be in the bay at all times to observe patients.
2. For each patient to be assessed for the need of a falls alarm bed and the reason for not using documented in patients notes.
3. To escalate delays and review discharge plans for medically fit patients in order to reduce length of stay and risk of harm.

2020/1129 Sub-optimal care of a deteriorating patient, Outwood Ward

The incident was the missed opportunity to recognise a sick septic child, who had presented to the Child Assessment Unit. She re-presented the following day in a worse condition, requiring admission to intensive care unit. She subsequently passed away.

The investigation found that the clinical team failed to undertake a barium enema which may have identified the lower gastrointestinal stricture caused by the child's necrotising enterocolitis. The reason this happened was due to;

- Poor documentation from grand round
- Poor verbal handovers, especially consultant to consultant handover of a complex patient.
- Poor ownership and overseeing of patient by one named consultant.

The report acknowledged that even if a stricture had been found, it is difficult to be sure whether this would have changed her medical management and therefore changed the outcome.

The failure to recognise that she was possibly septic when she first presented (given what was a high heart rate for her), can be put down to a lack of notes, or summary of her case, being available on CAU. The investigation believes that even if her notes had been available, her usual bradycardia may have been missed. A summary of her case would therefore have been more useful.

The action plan addresses the following recommendations:

1. Implementation of a Grand Round documentation form, to be completed for each patient discussed at grand round by the paediatric team. This has already been started and needs to be finalised.
2. Review of paediatric handover policy, to mandate consultant to consultant handover, especially of complex patients, especially from a Friday to weekend consultant, and from a weekend to weekday consultant of the week.
3. Quality improvement project work regarding ensuring a named consultant is in charge of every patient on Outwood ward, and that they are regularly updated regarding the child's stay in hospital.
4. Re-educate paediatric staff regarding ensuring patients are booked in CAU diary if medical review required so that notes are available.
5. A folder with a summary letter of the main issues for each passport patient has already been started, to be available in CAU and Paediatric emergency department.
6. This has only recently been instituted, and many patients do not yet have a letter in this folder. This process is to be reviewed, to ensure this system is used by all consultants.

7. Continuing with medical workforce plan and implementation of a second registrar being available for CAU on weekends.
8. Re-educate paediatric team regarding the fact that, while a patient is in our hospital, they remain our responsibility, and should not be left without a medical team once transfer teams arrive.
9. Communication skills teaching for medical and nursing teams.

In order to address concerns raised by the family the Trust requested an independent review of the case and serious incident report. The Clinical Advisor to the Surrey Heartlands Women's and Children's Programme who is a Consultant Paediatrician and neonatal intensivist agreed to review the case.

The reviewer reported 'a very open, honest and candid RCA investigation……. Although the outcome was sadly tragic, there is no indication of any lack of concern, caring or capability by any individual. It seems clear to me that the paediatric team has looked very hard to see how they could reduce the chances of a similar situation happening again.'

The Scrutiny Panel closed one serious incident investigation in December 2020.

2020/10098 Treatment delay, ED
The patient, a 26 year old male patient, suffered a cardiac arrest whilst awaiting treatment in the Emergency Department (ED) and the incident was declared to explore whether there was an opportunity to intervene.

The investigation found insufficient treatment was given to protect the heart from the effects of severe hyperkalaemia. The first-line cardio-protective treatment (calcium chloride) was not available due to a national shortage. The dose of the alternative (calcium gluconate) and any requirement to give different doses to calcium chloride was not clear in the ED guideline in the event of hyperkalaemia. Potassium-lowering treatment was delayed because no pump was available in the HDU for administration of insulin. There was a missed opportunity to give a second dose of calcium gluconate after 30 minutes, or to start alternative potassium-lowering treatment (salbutamol), because the treating clinicians had become focussed on the need to find a pump.

One of the immediate actions following the incident was for four pumps to be made available for HDU at all times. Permanent shelving has been installed to house the pumps. Emergency guidelines will be written with clear guidance on the doses and administration of medications which may need to be given in an emergency situation – they will also be reviewed in the context of national shortage alert. Where medication shortages necessitate a change in practice, guidelines will be reviewed and updated to reflect this, and important changes will to be clearly communicated, particularly where this applies to emergency, time-critical treatment.

8. HSIB investigations (serious incidents)

None closed.

10. Recommendation

The Trust Board are asked to discuss the report and take assurance regarding the management of SIs and the on-going work to improve performance on completing SI investigations within the National timeframe.

Jane Dickson
Chief Nurse
January 2021

Appendix 1: Duty of Candour Compliance Report, January 2021

The Trust is required to comply with Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities), Duty of Candour.

Table 1 summarises Duty of Candour compliance where it applies to Serious Incidents closed by the CCG in the previous month. Where Duty of Candour has not been applied an explanation will be given.

Table 2 summarises outstanding Duty of Candour compliance where it applies to patient notifiable incidents reported since April 2015. In some cases the investigation and management may be ongoing. The date shown is the date that the incident was reported and therefore the point at which the Trust became aware.

It should be noted that Duty of Candour compliance is reviewed as a standing agenda item at the Patient Safety and Clinical Risk sub-committee.

Table 1: Trust Serious Incidents closed in November and December 2021

Division	SI ID	Category	Copy of final report offered to patient/family
Closed in November			
C&D	2020/13488	Fall	All elements of the Duty of Candour process have been completed. The investigation report has been shared with the family (30/11/20).
C&D	2020/5609	Fall	The investigation report was shared with the family (01/12/20).
WaCH	2020/1129	Sub-optimal care of a deteriorating patient	The investigation report and independent report have both been shared with the family.
Closed in December			
Medicine	2020/10098	Treatment delay	The patient is aware of the investigation and would like to see a copy of the final report. This will be sent to him.

Table 2: Outstanding Duty of Candour compliance for adverse patient safety incidents assessed as moderate harm, severe harm or death reported since April 2015

	Cancer	Medical	Surgical	WaCH	Total
Mar 2019				1	1
Apr 2019					-
May 2019					-
Jun 2019		1			1
Jul 2019		1			1
Aug 2019					-
Sep 2019		2			2
Oct 2019		1			1
Nov 2019		1			1
Dec 2019		1			1
Jan 2020		4		1	5
Feb 2020		2			2
Mar 2020		1			1
Apr 2020		5			5
May 2020		4		2	6
Jun 2020		3	1		4
Jul 2020		2	1	1	4
Aug 2020		5	2	2	9
Sep 2020		2	2	5	9
Oct 2020		8	10	3	21
Nov 2020	1	4	5	2	12
Dec 2020		8	4		12
Jan 2021	1	7	3	1	12
Total	**2**	**62**	**28**	**18**	**110**